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No. 96-1426

In The

Supreme Court of the United States

October Term, 1996

DONALD HUTTON, Personal Representative of the Estate of Erric Hutton,

Petitioner,

vs.

THREE RIVERS AREA HOSPITAL,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTION PRESENTED FOR REVIEW

The petitioner's petition asks the Court to review and reverse the Sixth Circuit's interpretation of "appropriate medical screening examination" as used in the Emergency Medical Treatment Act (EMTALA), 42 U.S.C. § 1395dd. The Sixth Circuit holds that "appropriate" means "care similar to care provided to any other patient." It says that a screening examination that is not appropriate is one that is "deficient in any way peculiar to the patient's characteristics," including, but not limited to, the patient's "sex, race, national origin, financial condition, politics, social status." The Sixth Circuit holds, then, that the petitioner must show a screening examination was inadequate as a result of improper discriminatory motive, not negligence. The petitioner contends, on the other hand, that "appropriate" should be interpreted so that it is measured by a negligence standard, thereby making the federal law duplicate state medical malpractice law.

LIST OF PARTIES

The petitioner is Donald Hutton, Personal Representative of the Estate of Erric Hutton. The respondent is Three Rivers Area Hospital.

Three Rivers Area Hospital has no parent or subsidiary companies.

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OPINIONS BELOW

The opinions and orders of the United States Court of Appeals for the Sixth Circuit were entered on November 1, 1996 and December 9, 1996. Neither was published. They are included as D-16 and E-18 in the Petitioner's Appendix. The opinions and orders of the United States District Court for the Western District of Michigan, Southern Division, were filed on May 11, 1995, and October 2, 1995. Neither of those was published. They are included as A-1 and B-3 in the petitioner's appendix.

STATEMENT OF JURISDICTION

The statement of jurisdiction contained in the petitioner's petition is complete and correct.

STATEMENT OF THE CASE

The petitioner's decedent, Erric Hutton, underwent surgery in Kalamazoo on March 9, 1994, for a chronic bowel problem. He was discharged from the Hospital on March 17. He presented at the emergency room of the respondent, Three Rivers Hospital, on March 21, 1994, complaining of chest pain and shortness of breath. He was examined, treated and discharged. Later that evening he died from a pulmonary embolism.

The petitioner, personal representative of his estate, has brought this action seeking damages under 42 U.S.C. § 1395dd. He claims the emergency room physician was negligent for not having administered a test which would have determined that Mr. Hutton was suffering a pulmonary embolism.

The respondent moved for summary disposition in the District Court for the reason that the petitioner's complaint

alleged only negligent care, but not that it was improperly motivated. The respondent relied upon the Sixth Circuit's prior interpretation of the statute in *Cleland v. Bronson Health Care Group*, 917 F.2d 266 (6th Cir. 1990). The District Court held that *Cleland* does control, and that dismissal on the pleadings was appropriate. The court allowed the petitioner, however, to amend his complaint to allege a discriminatory motive. The petitioner did so by including allegations of age discrimination (Erric was 20) in the amended complaint.

The petitioner later agreed to dismissal of the amended complaint for the reason that there was no evidence at all of age discrimination or any other improper motive. The petitioner appealed to the Sixth Circuit where he claimed that *Cleland* was incorrectly decided or that it is no longer valid, given certain amendments to other provisions of the statute. He argued that his original complaint was sufficient to state a cause of action under 42 U.S.C. § 1395dd. The Sixth Circuit rejected the petitioner's arguments and affirmed the decision of the District Court for the reason that the matter was controlled by its prior decision in *Cleland*. The court also denied the petitioner's motion for rehearing en banc.

REASONS FOR DENYING THE WRIT

I.

42 U.S.C. § 1395dd IS INAPPLICABLE TO THIS CASE, GIVEN THAT IT WAS NEVER INTENDED TO CREATE, NOR DID IT CREATE, A FEDERAL CAUSE OF ACTION FOR MEDICAL MALPRACTICE.

A. Introduction.

Accepting the petitioner's allegations at face value and construing them in the light most favorable to him, the complaint

states a common law negligence claim against the Hospital. The question here is whether these allegations also support a federal statutory claim, which will, in essence, duplicate the state law medical malpractice claim.

The respondent contends that Congress never meant for EMTALA to create a federal action for ordinary medical malpractice claims. The Sixth Circuit agrees and first did so beginning in 1990 in *Cleland, supra*. *Cleland* says that a plaintiff bringing a claim under 42 U.S.C. § 1395dd must prove that alleged substandard medical care resulted from a discriminatory or other improper motive, to distinguish the federal claim from ordinary negligence claims.

The petitioner in this case alleges that Dr. Nomicos did not give competent care, but the petitioner does not claim that Dr. Nomicos had any improper motive. As discussed below, the Sixth Circuit has properly interpreted EMTALA, and the petitioner's allegations of negligence alone will not support a claim under the federal statute.

B. Congress Intended 42 U.S.C. § 1395dd To Prohibit The Practice Of "Patient Dumping".

The phenomenon known as "patient dumping" occurs when a hospital capable of providing necessary medical care either transfers a patient to another facility or simply turns the patient away because the patient is unable to pay. The practice existed because the expense of treating uninsured patients creates economic incentive to "dump" them elsewhere, generally on public hospitals which must then care for the majority of uninsured patients.[1]

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1. *See Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. Rev. 1186 (1986); *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 13 Am. J. Law & Medicine 561 (Fall-Winter 1988).

42 U.S.C. § 1395dd, EMTALA's anti-dumping provisions, represent Congress' response to nationwide concern over the problem of patient dumping.[2] Section 1395dd requires, as a condition of participation in Medicare, that hospitals with emergency departments must provide "appropriate medical screening" of all patients seeking emergency care, regardless of the patient's ability to pay, to determine if an "emergency medical condition" exists.

If an "emergency medical condition" is detected, the hospital must treat the patient until the condition is "stabilized," meaning that no material deterioration of the condition is likely to result from the patient's transfer from the facility. 42 U.S.C. § 1395dd(e)(3)(A). If the patient has an "emergency medical condition" which has not been "stabilized" within the meaning of EMTALA, an "appropriate transfer" of the patient is permitted under certain limited conditions.

Significantly, if a hospital determines that the patient does not have an "emergency medical condition," EMTALA does not apply, and the hospital is free to transfer or discharge the patient.

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2. H.R. Rep. No. 241, 99th Cong., 1st Sess., Pt. 1, at 27, reprinted in 1986 U.S. Code Cong. & Admin. News 579, at 605:

> The [House Committee on Ways and Means] is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.

That is, if the emergency nature of a condition is not detected or ascertained despite an appropriate screening, the hospital cannot be charged with failure to stabilize a known emergency condition under EMTALA.[3] Further, even if the hospital finds an "emergency medical condition," EMTALA no longer applies, and the hospital may discharge or transfer the patient as it sees fit, once the patient is "stabilized."[4]

EMTALA provides a variety of enforcement mechanisms. A hospital may have its provider contract with Medicare suspended or terminated if it "knowingly and willfully, or negligently" violates the statute. § 1395dd(d)(1). A violating hospital may also be subject to civil monetary penalties for knowing or negligent violations. § 1395dd(d)(2)(A). Finally, EMTALA grants standing to an individual suffering personal harm from an EMTALA violation to bring a federal civil cause of action against the violating hospital. § 1395dd(d)(3).

C. The Plaintiff Seeks To Misapply 42 U.S.C. § 1395dd To A Claim That Is Essentially One Of Medical Malpractice.

Th petitioner attempts to apply § 1395dd to the factual situation in this case, but § 1395dd was not intended to be a vehicle for a federal medical malpractice wrongful death action. Congress would not approve such a use, because that would distort the statute's intended purpose as evidenced by its legislative history.

It is easy to see why the statute is so appealing from a plaintiff's perspective. The plaintiff would like to use the statute as a means of bypassing state tort reform measures. The

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3. *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 271 (6th Cir. 1990).

4. *Cleland*, at 271.

American Bar Association Journal noted a number of years ago that that plaintiffs' attorneys were filing EMTALA suits, instead of malpractice actions, because the federal statute permits injunctive relief; it makes the hospital the primary defendant instead of the doctor, thereby increasing the chance of tapping a "deep pocket;" and because it allows a plaintiff to establish liability by mere proof of a violation.[5]

D. A Cognizable Cause Of Action Under § 1395dd Requires Pleading A Discriminatory Or Other Improper Motive In The Hospital's Treatment, And In the Absence Of Such Allegations, Dismissal Is Proper.

The Sixth Circuit, in *Cleland v. Bronson Health Care Group*, 917 F.2d 266 (6th Cir. 1990), meticulously reviewed EMTALA's legislative history and interpreted its statutory terms and duties to require pleading and proof of a *discriminatory motive* on the part of any hospital sued under the statute. Its ruling that "discriminatory motive" is an essential element of an EMTALA claim has consistently been applied within the Sixth Circuit. *See, e.g., Hines v. Adair County Public Hospital District Corp*, 827 F. Supp. 426, 431-433 (W.D. Ky. 1993); *Tolton v. American Biodyne, Inc.*, 854 F. Supp. 505, 511 (N.D. Ohio 1993).

More specifically, *Cleland* interprets "appropriate" medical screening examination to mean "care similar to care provided to any other patient." *Cleland*, at 271. Accordingly, an inappropriate screening examination is one that is "deficient in any way peculiar to the patient's characteristics," *Id.*, at 269, including, but not limited to, the patient's "sex, race, national origin, financial condition, politics, social status." *Id.*, at 271. The *Cleland* analysis, at 271, states as follows:

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5. *ABA Journal*, November 11, 1988, pp. 17-18.

"Appropriate" is one of the most wonderful weasel words in the dictionary, and a great aid to the resolution of disputed issues in the drafting of legislation. Who, after all, can be found to stand up for "inappropriate" treatment or actions of any sort. **Under the circumstances of the act, "appropriate" can be taken to mean care similar to care that would have been provided to any other patient, or at least not known by the providers to be insufficient or below their own standards.** Plaintiffs essentially contend that "appropriate" denotes, at a minimum, the full panoply of state malpractice law, and at a maximum, includes a guarantee of successful result.

In one sense, in hindsight, the screening provided in this case could scarcely be called appropriate. The patient came in, he had a condition that was at least conceivably ascertainable by medical science, the condition was not ascertained, and he died within 24 hours. At the same time, **there is not the slightest indication that this outcome would have been any different for a patient of any other characteristics. Had his sex, race, national origin, financial condition, politics, social status, etc., been anything whatsoever, as far as can be gleaned from the complaint, the outcome would have been the same. Under these circumstances, we hold that the complaint simply fails to allege any inappropriateness**

> **in the medical screening in the sense required by the Act.** [Emphasis added].

Similarly, with respect to the statutory duty to "stabilize," prior to transfer or discharge (which, of necessity, only arises where a physician actually discovers an emergency condition during the course of a screening exam), *Cleland* again has ruled that a breach of the duty to stabilize requires pleading and proof of a discriminatory motive:

> The same reasoning applies to stabilization, though with even greater force. To all appearances, the plaintiff's condition was stable. He was not in acute distress, neither the doctors nor the patient or his parents made the slightest indication that the condition was worsening in any way, or that it presented any risk that might become life-threatening, or that it would worsen markedly by the next day.
>
> Again, in hindsight, any stability was quite short-run. The patient died. However, neither the normal meaning of stabilization, nor any of the attendant legislative history or apparatus, indicates that Congress intended to provide a guarantee of the result of emergency room treatment and discharge. In the hospital's opinion, the patient was stable, and they would have believed that a patient with any differing characteristics would have been stable. We therefore hold that within the meaning of the Act, the hospital did its duty to stabilize young Cleland, and there are no allegations in the

> complaint to the contrary. Therefore, dismissal under Rule 12(b)(6) is proper.

Cleland, 271.

The petitioner's fixation upon negligence in this case "cannot cloud the otherwise clear distinctions between claims under common law negligence and EMTALA's statutory causes of action." *Hines*, *supra*, at 434. As the court in *Hines* said, at 431-432:

> The Sixth Circuit noted that nothing within the statutory language or legislative history "indicates that Congress intended to provide a guarantee of the result of emergency room treatment and discharge." [*Cleland* at 271]. In other words, **Congress did not intend to create a federal tort of negligence or to require the application of a negligence standard in an analysis of either of these federal duties as an alternative to state medical malpractice claims.** [Emphasis added].

Indeed, there was no reason for Congress to have some special concern for malpractice in the emergency room setting that would justify a federal tort of emergency room negligence. That is properly the subject of state tort law and very adequately redressed in that setting. Congressional concern was with "patient dumping" caused by discriminatory motive, and nothing more. In short, given the obvious legislative intent, the statutory EMTALA action requires pleading and proof that the respondent Hospital had a discriminatory motive.

E. The Petitioner Concedes That There Was No Discriminatory Or Improper Motive In This Case.

The petitioner concedes there is nothing in this case to indicate that Dr. Nomicos had any discriminatory or improper motive. Consequently, comparing this case to *Cleland*, "there [is] no indication or allegation [or basis for inferring] that the care provided to [Erric Hutton], and the decision to discharge him were based on anything other than the best medical judgment of those employed by the hospital." *Cleland*, at 269. "There is no allegation that the screening was in any way different than would have been offered to any other patient, or was deficient in any way peculiar to the patient's characteristics." *Id.* "The allegation of 'failure to stabilize' before discharge is similarly based only on the outcome." *Id.* The petitioner "point[s] to nothing that indicates that the patient's condition at discharge would not have been considered stable for any other patient, nor is there any allegation of any facts known to the doctors at the time to imply that the patient was not stabilized." *Id.* In short, while the petitioner's complaint might state a traditional medical malpractice wrongful death claim under state law, it does not satisfy the prerequisites for stating a valid claim under EMTALA.

Finally, dismissal of the EMTALA claim does *not* leave petitioner without a remedy:

> It would require a cold heart indeed not to feel sympathy for the unfortunate and probably preventable circumstances which befell Plaintiff . . . The sequence of events and ultimate consequences must have been like a nightmare for Plaintiff. Indeed, Plaintiff has carefully set these facts as the centerpiece of his case. However, Plaintiff's

> fixation upon negligence misunderstands the federal duties imposed by [§]1395dd. The Court's natural sympathy for Plaintiff cannot cloud the otherwise clear distinctions between claims under common law negligence and EMTALA's statutory causes of action. Moreover, this result does not leave Plaintiff without a remedy, but merely limits the jurisdiction of the federal courts to consider his particular complaint. *Hines*, at 434.

The petitioner, were it not for recent tort reform measures in Michigan, would never have filed this claim in the Federal Court. The petitioner must not be allowed to make a strained and unintended use of EMTALA as a means of circumventing the proper avenue of remedy, state tort law. The Sixth Circuit has prohibited that misuse of EMTALA, and there is no reason for this Court to conclude that the Sixth Circuit did not interpret the statute properly.

II.

THE DECISIONS OF OTHER CIRCUITS WHICH DEPART FROM THE *CLELAND* ANALYSIS HAVE MADE SEMANTIC DISTINCTIONS THAT, IN PRACTICAL APPLICATION, MAKE LITTLE OR NO DIFFERENCE.

The petitioner points to decisions from the First, Fourth, Tenth, and DC Circuits which have departed from *Cleland's* conclusion that an inappropriate medical screening is one which has departed from the norm due to some improper motive directed toward the individual patient. In truth, these decisions do not depart greatly from *Cleland*.

Cleland says that an "appropriate" medical screening evaluation is one which does not depart from the care provided to any other patient. *Cleland* also concluded that EMTALA was not meant to be federal cause of action for medical malpractice. The decisions of the other Circuits are fully consistent with *Cleland's* conclusions on both of those counts.

The Sixth Circuit, recognizing that EMTALA was not meant to be a federal cause of action for medical malpractice, went on in *Cleland* to show how negligence is carved out of the definition. Obviously, whenever a plaintiff claims negligent screening and evaluation, he or she is claiming to have had a screening examination which has departed from the care normally provided to oth.. patients. If the alleged inadequate screening has resulted from negligence alone, however, *Cleland* and the decisions from other Circuits say that the claim does not come within the purview of the federal statute.

The *Cleland* court recognized that it needed to exclude situations resulting from negligence alone, and negligence is a state of mind. Consequently, the distinction that must be made concerns the medical provider's state of mind. Turning to state of mind, the *Cleland* court said that the question is not whether the screening examination was negligently performed, but whether it was refused, or less than provided normally, on account of some intentional discriminatory motive peculiar to the individual patient. In short, *Cleland* makes good sense, because it goes through the full analysis needed to distinguish EMTALA from ordinary state law medical malpractice claims.

The other Circuits which have said that they will not look to motive as a measure of "appropriate" have usually done so anyway. One of the best examples is the fairly recent decision of the Eighth Circuit in *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996). In that case, the

plaintiff had taken a fall from a tree, and he appeared at the emergency room complaining of pain and popping noises in his chest. He was examined and discharged but was not given a chest x-ray. He suffered complications as a result of a medical condition which would have been revealed by a chest x-ray. He claimed EMTALA violations for inadequate screening, alleging that any other patient presenting with his symptoms would have been given a chest x-ray.

The Eighth Circuit said that they would not look to improper motive as the test for adequacy of the screening evaluation, but they also rejected the plaintiff's EMTALA claim saying:

> The important point for us is that the very respect in which the plaintiff's screening is said to be non-uniform — failure to order a chest x-ray for a patient complaining of popping noises in his chest — is nothing more than an accusation of negligence. We accept for purposes of this appeal from a summary judgment the proposition that Summers in fact made this complaint, and that the doctor did not hear him, or forgot what had been said. (There is no contention that the doctor deliberately failed to order a chest x-ray.) This may have been medical malpractice, but if it is also an EMTALA violation, that statute has been converted into a federal cause of action for a vast range of claims of medical negligence. It would always be possible to characterize negligence in the screening process as non-uniform treatment, because any hospital's screening process will presumably include a non-negligent response to symptoms or

> complaints presented by a patient. To construe EMTALA this expansively would be inconsistent with the principles and cases set out earlier in this opinion.

Summers, 1138-1139.

The Eighth Circuit, despite its statement to the contrary, was looking to motive. It said that the plaintiff was accusing the hospital of nothing more than "negligence." It said that there was no contention the doctor had "deliberately" failed to order the chest x-ray. In the discussion which follows this quote, however, the court said that it focused on what the doctor "perceived" to be the plaintiff's medical condition. It said there was no EMTALA violation if the doctor provided care similar to care he would give to others with the same "perceived" condition. *Summers*, 1139.

Unfortunately, this last part of the Eighth Circuit's reasoning was flawed because it was entirely circular. The plaintiff in such cases is claiming that the doctor has misperceived a condition as the result of inappropriate screening and evaluation, not vice versa.

The Eighth Circuit should have stuck to its focus on motive. As it concluded, EMTALA is not meant to be a federal action for medical negligence. The only real distinction that keeps EMTALA from being a duplicate of state negligence law is that drawn by the Sixth Circuit in *Cleland*, and that requires a focus on motive. There is no good reason to upset that view of the statute.

III.

1990 AMENDMENTS TO EMTALA'S MEDICARE PROVIDER PARTICIPATION AND CIVIL PENALTY SANCTION PROVISION HAVE NOT UNDERMINED THE RATIONALE OF THE *CLELAND* DECISION.

The petitioner argues that the 1990 amendments to EMTALA have rendered *Cleland* obsolete and no longer controlling. The petitioner asserts, erroneously, that amendment of the standards applicable to EMTALA's civil penalty and Medicare provider sanctions automatically altered the standards applicable to EMTALA's civil action sanction.

The amended sanctions are separate and distinct enforcement mechanisms from the civil action sanction at issue in this case. The civil action sanction was not amended. *Cleland*, like the case at bar, involved a private civil action by a patient against a hospital under EMTALA's "civil action" enforcement provision, 42 U.S.C. § 1395dd(d)(3)(A). Again, this provision was not changed in any way by the 1990 amendments.

The 1990 amendments relied upon by plaintiff modified EMTALA's "Medicare provider agreement" sanction [42 U.S.C. § 1395dd(d)(1), as originally enacted] and "civil penalty" sanction [42 U.S.C. § 1395dd(d)(2), as originally enacted]. The petitioner in this case is not proceeding under either of those sanction provisions, nor was the plaintiff in *Cleland*, for the simple reason that neither of those sanction provisions create a private civil cause of action available to injured patients.

Under the 1988 version of § 1395dd(d), four separate and distinct enforcement mechanisms were available to redress a violation of EMTALA's requirements (only one of which was available to private plaintiffs):

(1) termination or suspension of the hospital's Medicare provider agreement by HHS for "knowingly and willfully, or negligently" failing to meet EMTALA's requirements. This enforcement mechanism is administered by and imposed at the initiative of the Secretary of Health and Human Services ("HHS"), and is not available to private plaintiffs. [*See Deberry v. Sherman Hosp. Ass'n.*, 775 F. Supp. 1159 (N.D. Ill. 1991)];

(2) a hospital was subject to a civil monetary penalty of up to $50,000 for each knowing EMTALA violation. This enforcement mechanism is enforceable only by the Federal government or one of its agencies, not by private plaintiffs. [*See Holcomb v. Monahan*, 807 F. Supp. 1526 (M.D. Ala. 1992)];

(3) a private civil cause of action against the hospital by a patient harmed as a direct result of the hospital's EMTALA violation. This is the *only* sanction available to private plaintiffs; and

(4) if a patient was transferred to a receiving hospital in violation of EMTALA, a suit by the receiving hospital against the transferring hospital for its financial loss as a result of the "patient dumping."

In 1990 [Pub. L. 101-508], Congress amended EMTALA's Medicare participation and civil penalty sanction provisions, because it wanted to clarify the standards applicable to those specific remedies.[6] The 1990 amendments changed the standard for imposing civil monetary penalties against participating

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6. H.R. Conf. Rep. No. 964, 101st Cong., 2nd Sess. 1990, reprinted in 1990 U.S.C.C.A.N. 2017, 2421.

Medicare hospitals from "knowingly" to "negligently" violating an EMTALA requirement. Again, the civil penalty and Medicare provider sanctions affected by the amendments [formerly § 1395dd(d)(1)&(2), now § 1395dd(d)(1)(A)&(B)] are not now and have never been available to private plaintiffs. EMTALA's private civil action enforcement mechanism for individuals personally harmed as a direct result of a participating hospital's violation of EMTALA [formerly § 1395dd(d)(3)(A), now § 1395dd(d)(2)(A)] was not amended in any respect, and the standards applicable to such private civil actions, as set forth in *Cleland*, remain in full force and effect and unchanged.[7]

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7. The sanction provisions, as amended in 1990, are set forth below, in pertinent part, for ease of reference:

(d) Enforcement.

(1) Civil money penalties.

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation . . .

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who --

(ii) signs a certification under subsection (C)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician

(Cont'd)

(Cont'd)

knew or should have known that the benefits did not outweigh the risks, or

(iii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. . . .

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(A)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm *Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal*

(Cont'd)

The 1990 amendments did not substantively change EMTALA's provision regarding the medical screening requirement [§ 1395dd(a)], which originally and still refers only to "an appropriate medical screening examination within the capability of the hospital's emergency department," except to explain that "capability" includes "ancillary services routinely available to the emergency department." The 1990 amendments did not substantively change EMTALA's provision regarding "necessary stabilization treatment" [§ 1395dd(b)(1)]. Because those terms are not specifically defined by the statute (and never have been). *Cleland*'s interpretation of those key statutory terms is still valid in cases premised on the civil action sanction provisions of the statute.

CONCLUSION

The petitioner has attempted to bring this straightforward medical malpractice case in the Federal Court under the provisions of EMTALA. The petitioner has done so in an effort to circumvent Michigan tort reform law, which he views as more restrictive than might be the remedy in Federal Court if he has a viable EMTALA claim.

(Cont'd)

> *injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate* [Emphasis added].
>
> **(B) Financial loss to another medical facility** Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

The Sixth Circuit holds that 42 U.S.C. § 1395dd was not intended by Congress to establish a federal tort action for medical malpractice. Congress meant the statute to address the problem of "patient dumping," a practice employed by some medical providers to avoid the financial consequences of treating patients who are without means to pay.

The Sixth Circuit's decision in *Cleland* interpreted § 1395dd in a manner consistent with that purpose. Thus, to make a viable EMTALA claim, the plaintiff must show "inappropriate" emergency screening or stabilization resulting from a discriminatory or improper motive (because the patient is unable to pay, or on account of race or sex, for example). The petitioner acknowledges here that there was no discriminatory or other improper motive on the part of the medical providers. He bases this EMTALA claim solely on allegations of incompetent care. That claim must proceed, if at all, under state tort law. It is not a proper EMTALA claim.

The petitioner argues *Cleland* is no longer valid given the 1990 amendments to EMTALA, but that argument is without merit. The amendments are to other provisions of EMTALA. There was no amendment of the provision under which the petitioner seeks to proceed in this case. Consequently, the Court's interpretation in *Cleland* of the provision at issue in this case remains unaffected. Congress did not change the language pertaining to the petitioner's claim here of "inappropriate" medical screening and failure to stabilize. The petitioner must still prove improper motive as the essence of this federal action. He admits that there is no evidence of improper motive.

The respondent asks, therefore, that petitioner's Petition for Writ of Certiorari be denied, and that the respondent be awarded its costs and fees incurred in this matter.

Respectfully submitted,

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